PARK SQUARE
BARRISTERS

Inquest touching the death of James Sheffield

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The inquest touching on the death of James Sheffield was heard in Bolton Coroner's Court over two days on 30th and 31st January 2018 by a Judge alone.

On 12th July 2016 Mr Sheffield had suffered a respiratory arrest whilst an in-patient at Salford Royal Hospital from which he never regained consciousness. Mr Sheffield had been admitted to Salford Royal Hospital following a fall at the Trafford Centre which resulted in hip pain. When investigated this indicated a pathological fracture to the hip. The hip fracture was caused by cancer of unknown primary but suspected to be renal. Mr Sheffield was admitted for a hip replacement.

Mr Sheffield had numerous co-morbidities including severe obstructive sleep apnoea (OSA) which meant that when he was asleep the muscles in his neck relaxed and obstructed his airway which would stop him breathing. OSA is rarely, if ever, life threatening as once breathing is obstructed the brain is alerted to wake up. Mr Sheffield had been prescribed a Continuous Positive Airway Pressure (CPAP) machine which is a mask he would wear when asleep and which exerts positive end expiratory pressure (PEEP) to keep the airway open. Mr Sheffield used the CPAP machine while in hospital. He also suffered from obesity hypoventilation syndrome (OHS) which is defined as the combination of obesity, hypoxemia (falling oxygen levels in blood during sleep) and hypercapnia (increased blood carbon dioxide levels during the day) resulting from hypoventilation (excessively slow or shallow breathing).

After several weeks' delay, much of which was spent on Ward B6, the hip operation took place. Aside from a difficult extubation the operation was uneventful and Mr Sheffield was stepped down from HDU to Ward B6, where he had spent several weeks prior to the operation. Shortly after arriving on Ward B6 Mr Sheffield had lunch, was heard snoring and seen to be without his CPAP machine and then suffered a respiratory arrest from which he never regained consciousness. His CPAP machine has never been located.

Approximately 45 minutes to 1 hour prior to the respiratory arrest, the notes recorded that Mr Sheffield had asked if he could remove his nasal cannula, which was delivering 5 or 6L of oxygen. It was not clear from the notes if the cannula was removed or not but a statement provided shortly prior to the inquest confirmed that it had been removed.

The family's key concerns were: -

a) Loss of the CPAP machine.
b) Why, when Ward B6 were familiar with Mr Sheffield's use of a CPAP machine, had it had not been realised that he had been asleep without his CPAP machine?
c) Conflicting information being given following the respiratory arrest about Mr Sheffield's treatment and prospects of recovery
d) An apology was never given as opposed to offers of condolences for the loss.

The medical notes provided flagged potential concerns with:-

a) Use of Morphine, which can be a respiratory depressant, against a backdrop of OSA/OHV.

b) Removal of the nasal cannula. The trust had undertaken a serious untoward incident report identifying that a bedside handover should have taken place. The nurse who has transferred Mr Sheffield said that she provided a telephone handover but none of the nurses in Ward B6 recalled it.

A statement had been provided for the purpose of the inquest giving hearsay evidence that Mr Sheffield had fragments of food in his mouth at the time of his arrest as if he had been eating. One of the questions asked of the pathologist by the representatives of the NHS prior to disclosure of the SUI report concerned whether Mr Sheffield could have choked on food as staff *"may say that immediately prior to his arrest Mr Sheffield was sitting up in bed eating his lunch and in fact during resuscitation efforts food debris was found in his mouth."*

This question raised two inferential points, the first that Mr Sheffield was not asleep at the time of his arrest, and therefore would not have been wearing his CPAP machine even if it had not been lost. The second inference, drawn by the pathologist when answering the question, was that Mr Sheffield may have choked in some way on food. The pathologist said that that there was no food debris within the airway and histological examination of the lungs did not suggest aspiration.

Consistent with the conclusion of the pathologist, disclosure of the witness statement provided for the preparation of the SUI report by the nurse who carried out the resuscitation included an observation that the particles of chewed up food were not obstructing the airway. The pathologist also noted in answers to questions the possibility that the immediate collapse was due to cardiac dysrhythmia but there was no direct supporting evidence. The bundle of documents produced by the trust for the inquest, unusually, placed the ECG records at the start, with Christopher Charlesworth from AvMA correctly predicting that the prime positioning of those records at the front of the bundle was an indication that the trust were going to implicate cardiac dysrhythmia as a potential factor.

The Evidence

The evidence was heard over two days from two consultants in intensive care medicine, the ward matron, two nurses present at the time of the arrest, a consultant anaesthetist, a consultant in general medicine, a family acquaintance who was with her son in an adjacent bed at the time of Mr Sheffield's arrest, the pathologist and Mr Sheffield's sister.

There was no getting around the fact that the CPAP machine should never have been lost, irrespective of whether it caused or contributed to the respiratory arrest. The trust had taken steps to prevent loss of equipment/ belongings on transfer of a patient by requiring a recording by not only the person giving the handover but also an acknowledgement by the ward receiving the patient. However, this was not sufficient as what it did not provide for was setting up of any handed over medical equipment on arrival at the new location. Therefore the Coroner made a Preventing Future Deaths report in relation to ensuring that whenever there is a transfer from one department to another, not just HDU or intensive care, the equipment must be put in place and in the possession of the person using it and made available to them as a matter of priority, even over lunch.

The evidence of the two nurses present at the time of the arrest and the family acquaintance visiting her son in the adjacent bed could not have been clearer that Mr Sheffield was snoring immediately prior to the arrest as it was his loud snoring, consistent with OSA, which resulted in the nurse looking in his direction and observing the moment he stopped breathing. Most of

the witnesses from the trust expressed their sorrow, either when giving evidence or outside the court room, which was important to the family. There was also an acknowledgement by one of the witnesses for the trust that he would have weaned Mr Sheffield off oxygen more slowly than in fact occurred although it was noted that there was no evidence that Mr Sheffield was seeming clinically hypoxic.

The coroner gave a narrative conclusion that Mr Sheffield died as a recognised complication of postoperative recovery to treat injuries sustained in an accidental fall and naturally occurring disease, giving risk to a susceptibility to respiratory failure on a ground of pre - existing co - morbidities.

The Coroner said that he could not making a finding to the required standard in relation to the effect of the morphine, the propensity for hypercapnia and the possibility of susceptibility to hypoxia. He also said, *"On the Public Record; I convey to the family the dignity they brought to the inquest; the thoroughness of preparation of medico-legal issues; and the spirit in which they raised those issues deployed through their advocate and AvMA. No one could have asked for more than the assistance provided by Ms Wood [Counsel] and that Ms Wood had from AvMA."* From my own perspective it was a privilege to represent the family.

Conclusion

Consider in advance all the possible avenues for alternative causes of death where a person has multiple co - morbidities. Disclosure of documents: In this case the SUI report, containing statements made closer in time to the happening of the event, was sought and provided. The actual witnesses to the event need to be called to give evidence, in this case the nurses present at the time of the arrest, in addition to the ward matron who was not present but who provided a statement comprising hearsay evidence, for the purpose of the inquest.

This article was first published in the AvMA newsletter sent to their lawyer service members. The AvMA website can be found here.

Caroline Wood provides representation at inquests and pre – inquest reviews. She is particularly interested in inquests arising in healthcare settings, road traffic accidents and accidents at work which dovetail with her clinical negligence and personal injury practice.

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